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# Service innovations: the role of a consultant in old age psychiatry

## Experience of an adapted model of care

There is increased recognition that the role and function of a consultant psychiatrist is ill-defined and associated with excessive workloads, low job satisfaction, high levels of stress and high rates of premature retirement (Kennedy & Griffiths, 2001). This has led to an examination and debate about how consultants in general psychiatry could adapt models of working to address these difficulties, and also face the agenda of change facing the NHS as a whole and the mental health services in particular (Kennedy & Griffiths, 2001; De Silva & Sutcliffe, 2003). These challenges are not, of course, unique to general psychiatry, but as yet, there has been little debate about how consultants in other specialities, including old age psychiatry, could begin to try and address these difficulties. This article aims to stimulate debate, by describing an adapted model of working adopted by two consultants in old age psychiatry within the Hull and East Riding Community Health NHS Trust.

## The need for change

Until August 2002, the old age psychiatry service in eastern Hull was sectorised in the traditional geographical manner. A community mental health team (CMHT), with one consultant psychiatrist and one senior house officer (SHO) working as integral members, covered a socially deprived urban catchment population of approximately 18 000 people over the age of 65. All non-urgent referrals were directed through the CMHT, debated at a weekly meeting, allocated to individual workers and re-discussed following assessment at the following meeting. Urgent referrals were either dealt with by a community psychiatric nurse member of the CMHT, who provided urgent cover on a rota basis, or by the consultant, depending on the needs of the patient as determined by the referral information.

However, despite this system of care, there were high rates of morbidity, high rates of seemingly inappropriate urgent referrals (often with inadequate referral information and/or primary care assessment), feelings of clinical isolation arising from being based across scattered community units and difficulties associated with medical/psychiatric cross-cover arrangements for annual leave and sickness. This led to low job satisfaction and a general feeling of 'burnout', low morale and dissatisfaction.

Attempts at trying to address some of these issues through the provision of educational events for social service and general practitioner colleagues, and outreach and liaison work over a number of years had largely failed. The employment of an agency locum to cross-cover a period of annual leave for a colleague in an attempt to reduce the burden proved to be an expensive disaster. Something had to change.

## Development of a new model

Trust managers were able to recognise and acknowledge the pressures involved in working in such a socially deprived area and quickly realised that if the issues were not dealt with, there would be a very real prospect of losing medical staff, either due to sickness or job dissatisfaction. This process was facilitated by the trust management structure, which involves a consultant old age psychiatrist acting as a clinical lead/clinical director in old age psychiatry, working closely with a lead manager for mental health services for older people. Supportive and constructive discussions closely involving the consultant group led to the development of a new model of care. Little resistance to change was offered from primary care trusts or other stakeholders, as the posts were recognised as difficult to recruit into. The aim was to try and preserve the main advantages of working in a sectorised service ('geographical model') in terms of local knowledge and experience, team working and continuity of care, with some of the advantages of working in a 'functional model', such as the development of specialist skills and preserved time to practise while avoiding the disadvantages associated with each. In effect, a hybrid model of working was developed. The development of this model had implications for the whole old age psychiatry medical staffing structure, which was modernised and re-engineered. Monies previously used



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to finance clinical assistant time (a remnant of the old asylum days) was redirected in order to enhance funding available to pay for consultant time and staff grade posts across the trust in old age psychiatry.

In effect, this innovative re-engineering of finances increased the available funding in the eastern Hull and Holderness areas from one and a half to two funded consultant posts. This arrangement was essential to the development of the new model of working across these areas.

## An adapted or 'hybrid' model of care for eastern Hull and Holderness

The model developed involves each of these two consultant posts having a commitment in eastern Hull and working closely with the CMHT in this area. However, while the first of these posts works purely within the urban area of eastern Hull, the other also has a commitment to Holderness, a rural area east of the city of Hull with a catchment population of approximately 10 000 people over the age of 65. The division of labour between the two consultants working within the eastern Hull sector is non-geographical, although there is an expectation that the first postholder will see approximately three times the number of referrals than the second within eastern Hull. The aim is to roughly balance the workload between the two consultants across the wider catchment population in terms of referrals seen.

Both posts provide sub-specialisation across the wider catchment population area, including the opportunity to be involved in service development across the whole trust in their area of interest. One consultant takes the lead for old age hospital liaison psychiatry, and the other provides the lead for dementia drug prescribing/memory clinic work and family therapy. Communication and teamwork is enhanced by both consultants attending the CMHT meetings in eastern Hull, as well as the same in-patient ward round. We also share an office. There is an expectation of continuity of care, so those patients initially seen by one consultant will be managed by that consultant, unless there is good reason not to do so (e.g. changing needs, patient choice). Protected time is made available for continuing professional development (CPD), as well as areas of special interest and personal/service development. The consultant partner covers this time. An SHO and specialist registrar work across the sector, although educational supervision is provided by one of the consultants. Working arrangements are described in the two job descriptions, and detailed further in the consultant job plans, with an in-built review of the system of working and care.

It is now more than 18 months since we began to work with this model, and we believe that it has a number of inherent advantages to the consultants involved, the CMHT, the trust as a whole and to patients. Although we do not have any relevant or appropriate quantitative data to support our claims (indeed, it would be almost impossible to do so!), the following discussion takes into account qualitative feedback from the stakeholders involved.

### Advantages and disadvantages of the model

Cross-cover arrangements for annual leave, training, sickness, etc. are straightforward. Patients might have been discussed within previous multidisciplinary team meetings, or during in-patient ward rounds when both consultants have been present, providing some insight into the plan of care, even if they have not been directly involved. In some cases, the covering consultant may have previously seen the patient. This makes it easier to 'pick up the strands' of a situation and deal with it appropriately. The CMHT greatly values this continuity. The consultants also work broadly with the same set of general practitioners, allowing continuity in the liaison with primary care when one consultant is absent.

A particular advantage of the model is the availability of 'protected time'. This allows consultants the space and time to pursue their areas of interest. It is a particular advantage not to have to be 'on call' to the sector all of the time during working hours. This reduces stress, and allows planning for family and social arrangements (a particular concern had been the dread of the late afternoon urgent referral when arrangements had been made for the early evening). Time used in such subspecialties has greatly enhanced the quality of the old age psychiatry hospital liaison service, as appreciated by consultant geriatrician colleagues, and allowed the service to begin to address the demands of the National Institute for Clinical Excellence guidelines (2001) on cholinesterase inhibitors, as well as offer family/systemic therapy.

The working arrangement also ensures that a consultant is present at all multidisciplinary team meetings, including in-patient ward rounds, even when one of the consultants is absent from work. This facilitates and enhances confidence in risk sharing and risk management discussions and decisions during meetings. When both consultants are present, there is an enhanced quality and depth of debate to multidisciplinary team discussions, with each consultant bringing their own ideas, experience and training, contributing to a more holistic view of the patient being offered. Multidisciplinary team colleagues report that debates on patient care 'allow practitioners to express their views, are interesting and educational, enabling staff to develop professionally'.

Clinical isolation is no longer an issue for the psychiatrists involved, who can sound out ideas and informally discuss patients and difficulties with the other consultant in a relaxed and non-threatening atmosphere. Furthermore, formal second opinions on difficult cases are easy to obtain, when required. Patient choice has also been improved, with a small number of patients transferring to the care of the other consultant. Feedback from junior doctors working with the system has been very positive, with trainees suggesting that they highly value working in the model with the two consultants, and that they believe that the



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depth and quality of their training has been enhanced as a result. From a trust managerial perspective, although there was an initial need to increase resources, this has already been balanced out (with an enhancement in quality) by eliminating the need to use agency or locum staff. Finally, but perhaps most importantly from an individual consultant perspective, job satisfaction has greatly improved, stress levels are very much lower and our working lives have greatly improved.

Although there was some initial confusion amongst multidisciplinary team staff more used to a traditional way of working, time and experience of the model has largely resolved this, and staff now feel confident in this way of working and greatly value its advantages. However, the model does necessarily rely on a good working relationship, mutual trust and respect between the consultants, as well as a degree of consistency of approach. This is an area of strength in the current consultant partnership, but could become an issue should the personnel change, if the implications for the service have not been fully thought through, or if the consultants involved had very different working styles. The model very much relies on teamwork in its broadest sense, lying at the centre of good-quality care for older people with mental health problems.

## Conclusions

The development of this adapted/hybrid model of care was only possible within a framework of active dialogue and close working relationships with trust managers. This involved the initial recognition and acceptance that a problem existed within the system rather than with any one individual, an understanding of the difficulties and issues concerned, a degree of innovative thinking in order to try and identify a model that could address the unique local needs and a willingness to take a risk in 'making it work'. We think it has been worth it.

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